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ABSTRACT

This practicum was designed to increase the awareness and HIV/AIDS literacy of child and youth professionals in a school, agency or ministerial setting. Children and youth were not being provided with factually correct information because the adults had no formal instruction and/or HIV literacy training. Workshops were designed and materials prepared explaining and defining the role of child and youth professionals in the AIDS crisis. Additionally, plans were developed which present a holistic picture of the AIDS crisis and how to respond. Lessons/manuscripts were developed to be utilized collectively or singly to increase the HIV literacy of the professionals in the work setting. This information was also presented to various schools, agencies, churches, and a local medical school. Analysis of the data revealed that many child and youth professionals are grossly misinformed as to the modes of transmission of HIV, methods of preventing the spread, and the segments of the population which are most at risk. When prepared with factually correct information, the child and youth professionals can make appropriate decisions in their personal lives and can be prepared to make a difference in the lives of children and youth. Six tables and the survey instruments are included. Contains 43 references. (Author)

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ED 383 943

Increasing the Awareness of Child and Youth Professionals in the AIDS Crisis

by

Norman Dale Norris

Cluster 58

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A Practicum I Report Submitted to the Ed. D. Program
in Child and Youth Studies in Partial Fulfillment of the Requirements for
the degree of Doctor of Education

NOVA SOUTHEASTERN UNIVERSITY

1994

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This practicum report was submitted by Norman Dale Norris under the direction of the advisor listed below. It was submitted to the Ed. D. Program in Child and Youth Studies in partial fulfillment of the requirements for the degree of Doctor of Education at Nova Southeastern University.

Approved:

August 22, 1994

Date of Final Approval of Report

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In Memory of

David Rowland Hunter

Francis "Frank" Ishmael

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ABSTRACT

Increasing the Awareness of Child and Youth Professionals in the AIDS Crisis. Norman Dale Norris, 1994: Practicum Report, Nova Southeastern University, Ed.D. Program in Child and Youth Studies. School Psychologist/ HIV Education/ Special Education/ Inservice Training/ Supervision/ Ministry and AIDS.

This practicum was designed to increase the awareness and HIV/AIDS literacy of child and youth professionals in a school, agency, or ministerial setting. Children and youth were not being provided with factually correct information because the adults had no formal instruction and/or HIV literacy training.

Workshops were designed and materials prepared explaining and defining the role of child and youth professionals in the AIDS crisis. Additionally, plans were developed which present a holistic picture of the AIDS crisis and how to respond. The writer developed lessons/manuscripts to be utilized collectively or singly to increase the HIV literacy of the professionals in the work setting. This information was also presented to various schools,agencies, churches, and a local medical school.

Analysis of the data revealed that many child and youth professionals are grossly misinformed as to the modes of transmission of HIV, methods of preventing the spread, and the segments of the population which are most at risk. When prepared with factually correct information, the child and youth professionals can make appropriate decisions in their personal lives and can be prepared to make a difference in the lives of children and youth.

* * * * *

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5/31/94 Norman Dale Norris

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FOREWORD

Any procedure and practice described in this practicum should be applied by the child and youth professional under appropriate supervision in accordance with professional standards of care used with regard to the unique circumstances that apply in each practice situation. The writer has taken great care to confirm the accuracy of the information presented in this practicum and to describe generally accepted factual information and practices. The writer cannot accept any responsibility for errors or omissions or for consequences from application of the information in this practicum and make no warranty, express or implied, with respect to the contents of this practicum.

CHAPTER I

INTRODUCTION

Description of Community

The community where the practicum took place is a small rural town located in the South. The community is rather isolated but is not located far from a major port city of great historical significance. The area is rather sparsely populated. There are styles and choices of homes in the community to suit various financial and socioeconomic levels.

The people in the community earn their living in a variety of ways. There are chemical plants in the area facilitating easy employment for many. There are relatively few private businesses in the area. The entrepreneurial endeavors which do exist are geared to attract the plant workers i.e. - restaurants, small grocery stores, etc. Many people work in some aspect of the fishing industry. Most professional people in the community commute to other areas to work. The community is ethnically mixed with equally varying levels

of education.

Writer's Work Setting and Role

The school district in which the writer is employed, although rural, is quite progressive both in its thinking and educational practices. Many state level programs are piloted there and the professional attitude among the teaching staff is generally enthusiastic and willing to experiment. With budget cuts seeming inevitable, the district still considers instruction in the arts and humanities to be of high priority. Test scores at all levels are consistently above the state and national averages, particularly in math.

The district has a very strong program of staff development. The district is concerned enough with these issues to pay teachers additional monies for attending staff development programs. In the experience of this writer, it is unusual for a district not to use professional consultants for staff development but instead to use the practicing classroom teacher. It is the general feeling among teachers that the district chooses to treat them as professionals. In keeping

with the progressive spirit of the district, the campuses are arranged in various ways. It is not unusual to find various groupings throughout the community - i.e. - a K-2 campus, K-6 campus, 3-6 campus, etc. This writer serves as an elementary music teacher in two schools; K-2 in one building and 3-6 in another. The days spent teaching are alternated in each building.

In each building there are various groupings of children and various special programs in place including but not limited to Resource, Chapter I, Bilingual, and even one deaf child in the lower grades. This writer sees each child in the building at least one time weekly, and is therefore in a position to see various types of teaching and learning styles and to possibly assess the needs of children on a more general basis than one group at a time. It has been the observation of this writer that the students in the area schools generally come from stable home backgrounds with quite traditional values. The writer has likewise observed that parental support and effort are much stronger than in other places and that discipline problems (ordinary to the schools of the 1990's) do not exist there. Overall, the school and district are a very pleasant, happy place.

This writer has a very diverse background as a student, teacher,

educator, and performer. The writer has 12 years of teaching experience both as a choral director and elementary classroom teacher. Likewise, for as many years the writer has served in various capacities as a church musician and minister of music. The writer's background includes the bachelor's and master's degrees in music (choral music education and piano performance) and, at the time of this writing, is a second year doctoral student.

The writer chose this topic because it is not only timely but a problem that is moving into segments of society previously not considered at risk. The writer, as a teacher and minister, has dealt with the loss of several co-workers to AIDS. As a father and uncle the writer is very concerned that children have the correct information about HIV and AIDS. With the support of family and friends the writer recognizes the completion of this practicum as an opportunity to affect positive change.

CHAPTER II

STUDY OF THE PROBLEM

Problem Description

The problem is that children/teens/youth are not given factual information about the transmission and prevention of the spread of HIV, the virus believed to cause Acquired Immune Deficiency Syndrome (AIDS). While this is not a situation which was rampant or out of control in this writer's work setting, it is a global problem which affects the children in this wriiter's work setting as much as any other. The problem is further compounded in that the adults (teachers and other child and youth professionals) are likewise given very little, if any, preparation to adequately answer questions concerning HIV/AIDS when asked.

It is the position of this writer that the adults (teachers and other child and youth professionals) must be appropriately prepared with correct information so that their children can likewise be prepared to prevent further useless tragedy. When children are not given

factual information they are at greater risk of infection than other segments the population.

Problem Documentation

When AIDS first surfaced and baffled the medical community in the late 1970's it seemed isolated in one small segment of the population, specifically among homosexual males. Within a relatively short time it has spread to other segments primarily through promiscuous sexual behaviors (left over from the free thinking of and 1970's), through intravenous drug use, and through a tainted blood supply. At the time of this writing, the nation's blood supply is thoroughly screened. Therefore this danger is virtually past. With the current level of medical research, the medical community can confidently say, "We know what does and does not transmit HIV".

Although the crisis is far from over, there is evidence in the research showing the transmission rate dropping among previously targeted high risk groups. According to T. Seale (personal communication, January 17, 1992) "More people in previously considered high risk groups are taking responsibility for their behavior

to reduce the risk of transmission." The Journal of the American Medical Association (August 12, 1992) reports that in 1991 the number of AIDS cases traced to homosexual/bisexual behaviors dropped considerably from 1990 while the cases of AIDS in women, heterosexual men, and IV drug users increased significantly.

The existence of the problem is documented, in part, by what is essentially a lack of documentation. After searching through administrative and faculty inservice records this writer found no evidence to indicate that the adults had been provided with any type of professional training which would prepare them to appropriately answer questions about HIV/AIDS when asked. The writer was told informally by a colleague that during previous school years some brief training had been provided in the appropriate manner in which to clean up bodily fluids. The writer was told by five teachers that the information was "sketchy" and told by another that the extent of their training had been "certainly inadequate." Subsequently, the writer did find a very old chart on the wall of the custodial closet outlining the appropriate manner of cleaning up a bodily spill including the use of rubber gloves and which cleaning solutions to use. The chart did not specifically address the prevention of the spread of HIV.

The writer searched through the science textbooks used by the school district. In the entire series (grades K-6) there were two paragraphs devoted to AIDS in the 6th grade textbook. The information given was little more than a definition.

Over a period of several weeks the writer took notes and talked informally with a total of 41 teachers, administrators, counselors, and para-professionals. As a result of this communication, the writer compiled the following information:

- 36 of 41 adults (teachers, administrators, counselors, and para-professionals) indicated they had been provided with very little/minimal professional training in HIV/AIDS education;
- 37 of 41 adults (teachers, administrators, counselors, and para-professionals) indicated they felt a need for some type of training which would go "beyond the surface";
- 35 of 41 adults (teachers, administrators, counselors, and para-professionals) said they would feel inadequate to respond appropriately to questions about HIV or AIDS if asked;
- 37 of 41 adults (teachers, administrators, counselors and para-professionals) indicated they would not know an appropriate agency or referral service to direct students or

parents for help (one adult did indicate his church was involved in an AIDS outreach ministry).

Although not directly relevant to the specific work setting of this writer in terms of calling the particular school by name, Denson, et al. (1993) conducted a survey of about 100 high schools in the state where this practicum took place. The researchers' findings indicate that "for the majority of schools, in-service workshops for teachers and administrators were not provided. Schools with predominantly minority enrollments were less likely to devote time to HIV/AIDS education" (p. 309). These researchers indicated that teachers needed to be better prepared to initiate programs which provide for appropriate AIDS education. This published quantitative study included the district where this writer is employed as a teacher.

It is the opinion of this writer that the problem continues to exist because up to this point no one has taken exception with the issue and chosen to push forward with an idea for a developmental program. People typically disregard what makes them uncomfortable when there is no reason to confront it or when there is no way to do so in a manner that is not threatening or demeaning.

Causative Analysis

The causes of the problem of children and youth not being given factually correct information about HIV/AIDS as a result of adults being poorly prepared are multiple. There is an adequate body of research in which many theories as to why the problem exists can be found.

Teens and youth are often misinformed by the media depiction of American life that HIV/AIDS is not an issue for them. Television and movies portray an uninhibited sexual lifestyle as healthy and desirable. Much of the media attention to HIV transmission by drug use is played down as insignificant.

Further adding to the cause of the problem is that teens and youth are in very little contact with adults who have the correct factual information to provide guidance to them concerning HIV/AIDS.

Finally, there is little agreement among child and youth professionals and medical/social science professionals as to an appropriate means of disseminating factual information about HIV/AIDS. In this writer's work setting, 23 teachers surveyed gave very different opinions as to how AIDS education should be taught.

The opinions of the teachers ranged from the very conservative ("It's not our place to teach children these things") to the moderately liberal ("We must not give them the idea that it's OK to delve into sexual matters before they're ready").

Relationship of the Problem to the Literature

A great deal of literature has been generated in recent years indicating not only the need for further study but reporting the efforts of other educators in an attempt to make a difference in the HIV/AIDS crisis. To say education is "the only vaccine we have now" is certainly true but a gross oversimplification of the need pressing educators. In designing educational programs to curtail the spread of HIV/AIDS, there are legal and ethical issues to work around as well as the necessity of focusing the program to meet the needs of the target audience.

Relevant to the topic of this practicum is research showing that currently the greatest rate of transmission of HIV is among heterosexual teenagers as a result of their behaviors. Weiner (1986) reports that the average person becomes sexually active at age 16.

Gibbs (1991) says that by junior high school 61 percent of the girls and 47 percent of the boys had engaged in sexual intercourse

Also relevant to this topic is what teens and youth do not know about the transmission of the virus. DuRant, Ashworth, Newman, and Gaillard (1991) conducted a study to measure what high school students know about HIV/AIDS and the risks involved. More than 50 percent of the subjects studied were mistakenly informed that HIV/AIDS can be transmitted through such means as mosquito bites, donating of blood and use of public toilets. Male subjects studied had less AIDS knowledge that females, Hispanics less than non-Hispanics, and black subjects had less knowledge than white subjects. Subjects with some formal HIV/AIDS instruction had more AIDS knowledge than those with no formal instruction.

Gardner, Millstein, and Wilcox (1990) report that "the onset of sexual activity is earlier in males than females, earlier in black adolescents, and earliest in black males" (p. 261). Among persons ages 13-19 who have been exposed to HIV the male/female ratio is 3:1.

The effort to design HIV/AIDS education programs which are effective and received well is often hindered by the depiction of the

AIDS crisis by the printed media. Lyons, Larson, et al. (1990) completed a study indicating that published literature addressing general AIDS topics is often not given the same quality of attention as other diseases which do not create the same medical dilemmas. In a comprehensive study, these researchers showed that AIDS issues received as much written attention as diabetes and lung cancer, but that most of the writings on AIDS were "letters to the editor" type writings rather than medical opinions or methodical research.

One of the greatest obstacles in HIV/AIDS education is working past the public attitudes about the disease and the targeted "high risk groups." Price and Hsu (1992) report extensive quantitative research indicating a direct correlation between the public attitude toward high risk groups and the public receptiveness to factually correct information. The level of education is linked positively with the probability that HIV/AIDS education will make a difference. Attitudes referred to as "response bias" by Catania, et al. (1990) often make the design of HIV/AIDS education programs difficult to implement. More specifically, when the volunteers in HIV/AIDS research are not an appropriate cross sample of the population to which the programs needed to be targeted, the intervention becomes guesswork.

According to Zeman (1990) teens today are facing adult-like stress at a much earlier age than in previous years. The breakup of families, money shortages, and child care necessities cause many teens to fill roles and accept responsibilities ordinarily expected of adults. Zeman report states that "teens are dating younger, paying more and tumbling into the back seat quicker" (p. 26). Waldman and Springen (1992) report that 74 percent of high school juniors work an after school job either to supplement family incomes or provide clothes and personal effects for themselves. The same report shows 84.5 percent of teenagers dating regularly.

The question of how the schools are supposed to respond to the AIDS crisis is one which puts any child and youth professional under tremendous political pressure. According to Corless and Pittman-Linderman (1988) many parents of school age children see the question of AIDS in the schools as an affront to the idea of school being a traditionally "safe" place for youngsters. It has been many years since the schools were in a situation which forced them to deal with any health related issues affecting masses of people. Vast amounts of misinformation coupled with media distortion of facts creates near panic in the public. The school systems are reluctant to

force an issue even when a rational decision is backed by clinical data. Responding to public pressure can create situations in which state and federal mandates are not met (i.e. - Public Law 94-142 which guarantees the education of any child regardless of the handicapping condition). The question of AIDS in the schools presents a vast array of issues as well as situations which are individual. The schools must be prepared to deal with whatever situation arises.

Slavin (1989) accuses our public schools of adopting programs which have not been adequately field tested. Our schools have repeatedly made certain mistakes in the presentation of intervention programs for other "crisis" type situations. Weiner (1986) states that educational programs which focus on a crisis are generally no more effective than any other curriculum that is well planned, sequential, and incorporated as part of the school's regular curriculum. Additionally, educators frequently have such rigid guidelines imposed on them by those who do not wish to make anyone uncomfortable by their programs that the programs lose their focus and purpose. This type of counterproductive behavior is what Senge (1990) refers to as the "learning disability" within an organization.

Fennell (1989) suggests a very direct approach where each

school system did not incorporate HIV/AIDS education into the existing curriculum but put separate, very intense programs in place which were directed and evaluated by trained staff. Likewise, Fennell indicates that school districts should reach out and bring in outside authorities on AIDS to speak to teachers and children including but not limited to criminology professionals, health professionals, and professionals in the ministry. Additionally, Fennell proposes that a large portion of each teachers time (meetings twice monthly) be allocated to keeping abreast of the crisis and the most current information to which all professionals have access.

Another controversial factor contributing to the problem of HIV/AIDS education is an apparent acceptance of an inherent homosexual inclination in adolescents. Recent medical research, specifically the Genome Project, has indicated differences in the genetic and chemical make-up of heterosexuals and homosexuals lending credence to what many counseling psychologists were seeing: teenagers who claim to be struggling with an inseparable homosexual tendency. Kinsey, Pomeroy, and Martin (cited in Weiner, 1986) wrote as early as 1948 that homosexual activity among men "is much more frequent than is ordinarily realized" (p. 184). The electronic and print

media are bombarded with stories of teenagers coming to terms with their homosexuality in the age of AIDS. Baker (1990) writes that "adolescence is never easy, but growing up gay has always been trying" (p. 60).

According to Ostrow (1987) many social science and education professionals are reaching out to the specific needs of homosexual youth. The difficulties encountered by homosexual youth seem to be created less by the homosexual orientation than by societal prejudice. It is the position of Ostrow that HIV/AIDS education programs targeted to homosexual youth will be most effective when the youth are protected from exploitation by adults and peers and when the general public has been educated to the specific needs of these special youngsters.

Adding to the difficulty in having adults appropriately prepared to discuss the AIDS crisis is the fact that there is little agreement among child and youth professionals and medical/social science professionals as to an appropriate means of disseminating factual information about HIV/AIDS. Educators and other child and youth professionals have long struggled with the question of where their professional roles fit in the AIDS crisis. Kaplan and Springer (1991)

report that the ACLU filed a lawsuit against a Wisconsin school system for teaching sex education classes from a point of view whereby "boys and girls sexual behaviors were stereotyped, birth control frowned upon, AIDS characterized as a statement on sexual behavior, and the two-parent heterosexual family considered to be the only model of the healthy family" (p. 69). Most educational institutions face the obstacle of teaching sex education that was free of values, morals or cultural bias because the general public is in disagreement as to the appropriate manner of presenting AIDS information to youngsters. It is often argued that AIDS prevention presented as anything other than sexual abstinence is only encouraging youngsters to experiment. It is thought by many researchers, including Kaeming & Bootzin (1990), that the one attitude which creates the greatest obstacle to effective HIV/AIDS education and intervention is the perceived susceptibility of contracting the disease. These researchers state:

> The researchers found that concern about AIDS was the variable associated most strongly with changes in sexual behavior. Eighty percent of questionnaire respondents were

"very concerned", 60 percent of persons who were "somewhat concerned", and only 28 percent of those "not at all" concerned reported behavior change (p. 48).

In attempting to overcome the same barrier of "self-perceived risk", Bandura (1990) completed a study indicating that programs to generate self-directed change should contain four components:

(1) Information designed to increase awareness and knowledge of health risks;

(2) Development of social and self-regulatory skills needed to translate informed concerns into preventative action;

(3) Building self-efficacy through guided practice and corrective feedback;

(4) Enlisting social supports for desired personal changes (p.9).

It is a concern of many that education and social science professionals must be aware of and subsequently design HIV/AIDS awareness programs which are sensitive to the needs of specific sub-groups in society. Croteau, et al. (1993) cautioned HIV/AIDS educators to be aware of "group-specific misconceptions about

HIV/AIDS that are barriers to effective prevention or behavioral change" (p. 291). Among other things, the researchers findings show that misinformation regarding the transmission of HIV was most prevalent among the minority communities which essentially put the minority youth at a greater risk for infection. Another qualitative report by Croteau, et al. (1993) reported that a random sample among African-Americans showed 37 percent of college students and 17 percent of high school students actually believed that HIV was created in a laboratory as a means of eliminating the homosexual and black segments of society.

In this same mode of thinking Magana and Carrier (1992) cited other problems when HIV/AIDS educators attempt to implement programs in the Mexican-American community. The reportings indicate an entirely different perception of heterosexual and homosexual roles among Mexican-American men, thereby likewise altering their perceptions of risk factors. It is the finding of these researchers that because of the cultural differences involved, much of the research data accumulated In the Anglo-American community is of very little use in the Latin-American community.

Many HIV/AIDS researchers spend inordinate amounts of time

trying to discern why one program or another did not fare well at the evaluation stage. Rugg, et al. (1990) cited that much of the prerequisite research which would facilitate effective HIV/AIDS education has not already occurred because of funding, politics, or whatever. With the prerequisite research not clearly established, the statistical procedures necessary for documentation can not be realistically used. These researchers further cited that so much media attention and hype has sent such varying messages that comparing one group against another group is difficult.

Other researchers such as Leap (1992) believe HIV/AIDS education programs should be designed which discuss the issues in the same jargon and vernacular as the participants in the program. It is this researcher's concern that those teaching about AIDS are frequently better educated and possibly at a higher socioeconomic level than those needing to be taught. As such, addressing concerns on the appropriate level is a source of problems.

Effective communication within a program is not only a child and youth concern. According to Longshore (1990), adults often misunderstand clinical terminology and medical nomenclature. This researcher was emphatic that facts must be presented in whatever

manner makes them understandable. A comparison is made of teaching youngsters about AIDS without discussing sex to teaching about baseball without the use of a "ball and glove" (p. 69).

Qualitative and quantitative research continue to indicate that the simple presentation of the truth and the facts surrounding the HIV/AIDS crisis would not in and of itself bring about change at the policy making level. Popham (1993) states emphatically that policy makers in education are failing miserably in doing their part to curtail the spread of HIV. Popham cites their ineffectiveness/lack of effort as a result of a very nebulous understanding of the role of the child and youth professional in the HIV/AIDS crisis as well as a response to social/political pressure to avoid causing "discomfort" among the masses.

Kaeming and Sechrest (1990) wrote extensively concerning the relationship between AIDS research and policy making practices. It was the point of these researchers that much of the current AIDS research was more of a response to a crisis than of carefully laid ground work and/or long term planning. As a result, much of what is known is haphazard or, at best, quite by accident. This cannot provide a smooth transition from research to prevention/ intervention

strategies.

House and Walker (1993) cited the lack of priority placed on HIV/AIDS at the federal level. These researchers stated the lack of funding and coordinated effort are due to the fact that "the casualties are not in the mainstream majority of society" (p. 71). These researchers stated:

> It appears that as long as AIDS stays on the margins among nonwhites, the poor, the gay, and women it will become just another unsolved social problem (p. 71).

The possibility/feasibility of a nationwide data bank to monitor AIDS research, costs, practices, information, and also to monitor diagnosed AIDS cases from infection to death is frequently discussed as a means of grasping control of the crisis. Hidalgo (1990) wrote of a prototype AIDS data base in the State of Maryland. The report indicated that the desired features would be such things as keeping an accurate number of currently diagnosed cases of AIDS, "person-based" files tracking the status of each victim's health, current research findings about behaviors of victims, treatment plans,

financial data, and the interlinking of educational programs. The one issue attacked so vehemently in an effort of this sort is that of confidentiality and privacy. It would be virtually impossible to conform to state and federal mandates regarding the privacy issues with a data base of this size. This journal publication included a disclaimer indicating the views expressed in the article were those of the author and not those of the Maryland Department of Health and Mental Hygiene.

In dealing with the centralization of HIV and AIDS management, Fleishman, et al. (1990) contend that large, centrally managed programs of HIV/AIDS education and care are more effective and provide better services than smaller programs. A number of smaller support and education organizations often duplicate some services while not providing others. While not without some lacking attributes, centralization provides a better overall quality of education and care.

AIDS education has taken a significant place in the field of criminal justice. Baxter (1991) reported on the HIV/AIDS education efforts of jail personnel. Educating incarcerated individuals creates difficulties in that the recipients of the training are generally forced to participate. The findings indicate this type of HIV/AIDS education to

be no more or less effective than other comparable programs. Implementing this type of program creates considerably more difficulties because of the prevailing attitude upon incarceration and their previous behavioral background.

In a related study, Lurigio, et al. (1991) wrote of the efforts to properly educate probation officers as to their professional role in the AIDS crisis. The HIV awareness program for probation officers presented in Chicago proved effective in reducing officers fears of contracting the disease from their normal interactive work with offenders and also clarifying many legal questions which arise when dealing with juveniles who are HIV infected or are at an extreme risk for infection.

The emergence of AIDS into society created numerous problems for churches. There is an adequate amount of published literature indicating a definite need for HIV/AIDS education for persons of all ages at the church level. Giles (1992) reports of a third-generation Baptist minister whose wife was infected with HIV through a blood transfusion in the early 1980's and subsequently their two children were born infected. The man eventually had to leave the ministry entirely and begin work in counseling.

The use of condoms as a means of preventing the spread of HIV has created some discomfort among many Catholic theologians. Drane (1991) wrote that many leaders in the Catholic church are finding it necessary to re-think their traditionally dogmatic stand on condom use as a means of birth control. When a situation presents itself whereby the question must be raised as to maintaining marital intimacy without infecting the marriage partner, obviously decisions must be made.

Unfortunately, when the printed and electronic media make an effort toward educating the public about HIV/AIDS, many times the information given borders on sensationalism rather than the presentation of usable facts which will ultimately save lives. Lynch (1993) reported how the media has skewed the public perception of where they fit in the AIDS crisis. As an example, the media may report "x" number of AIDS related deaths in a certain year but not put that number in perspective by telling that the number of cardiovascular related deaths were 36 times greater. While not incorrect, misleading information reported by the media can certainly affect public policy.

Finally, Winnett, et al. (1990) confronted the media and their contribution to effective AIDS education to pinpoint where they have

succeeded and failed. While the printed media must overcome obstacles in attempting to make a contribution to AIDS education, it is not nearly as visible or as scrutinized as the electronic media. It has been clearly shown in many research efforts that some segments of the population must hear that "you do this and don't do this" to keep yourself healthy. The electronic media does not have the freedom to demonstrate visually what can be told in writing. Only when people recognize the susceptibility of HIV infection and bypass the "hang-ups" can the media truly be an effective deterrent to risky behaviors.

CHAPTER III

ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS

Goals and Expectations

The following goals and objectives were projected for this practicum:

> The primary goal of this practicum is to provide adults with information which will allow them to accurately discuss the current level of information about HIV/AIDS with children and youth. Being adequately prepared with the correct information will allow them to alter their behaviors accordingly and will make them a source of information and/or risky behavior deterrent for children and youth.

Expected Outcomes

At the conclusion of the practicum the writer expected to see adults appropriately prepared to provide factually correct information

regarding the prevention of HIV/AIDS to children and youth. The writer expected adults to separate the facts from the rumors regarding the HIV/AIDS crisis in an articulate manner. The writer would see child and youth professionals verbalize why AIDS was a teenage problem and why the schools were unable to respond in an appropriate or effective manner. The writer would observe fellow child and youth professionals defining their role in the crisis.

In addition, the writer expected to see several specific outcomes. At the conclusion of practicum:

(1) 75 percent of the adults will correctly list 5 ways in which HIV is transmitted;

(2) 75 percent (33 of 44) of the adults will correctly identify the four bodily fluids which are known to transmit HIV;

(3) 75 percent (33 of 44) of the adults will list 5-10 methods of preventing the spread of HIV;

(4) 75 percent (33 of 44) of the adults will state 3 reasons our schools have failed in making a contribution to effective HIV education;

(5) 75 percent (33 of 44) of the adults will state 2-3 ways in which the electronic and printed media have

misrepresented the facts and/or misinformed the public in the AIDS crisis;

(6) 75 percent (33 of 44) of the adults will list several ways in which the churches have responded to the AIDS crisis;

(7) 75 percent (33 of 44) of the adults will list 4 attributes of an HIV/AIDS education program which are known to increase effectiveness;

(8) 75 percent (33 of 44) of the adults will state 3-5 reasons the teen population is a such a risk for infection;

(9) 75 percent (33 of 44) of the adults will state at least 5 ways to keep themselves risk-free when in an emergency situation which may put them at risk for HIV infection;

(10) 75 percent (33 of 44) of the adults will list 2-3 ways in which policy makers can effectively respond to the AIDS crisis at their level.

Measurement of Outcomes

The writer used a self prepared pre- and post-questionnaire to measure and determine the effectiveness of the implementation phase

of the practicum. The post-questionnaire measured all 10 of the outcomes. Generally,the pre- and post-questionnaire were different instruments but asked for some of the same information. The written instrument asked for some demographic (but not personally identifiable) information, some brief background information of the participant and questions to survey their current level of knowledge about HIV/AIDS.

It was presumed by the writer that total anonymity plus essentially a checklist type of format would increase the likelihood of participation and the truthfulness doing so.

For purposes of determining the success of the practicum, the HIV/AIDS information section of the pre- and post-questionnaires was actually scored/graded. To maintain privacy and for simplicity, a simple average was found of the scores on the pre- and post-questionnaires, respectively. When the pre- and post- -questionnaires were scored and compared, the writer accepted a 25 percent increase in the scores as successful.

CHAPTER IV

SOLUTION STRATEGY

Discussion and Evaluation of Possible Solutions

The problem addressed in this practicum was that children/teens/youth were not given factual information about the transmission and prevention of HIV. In attempting to devise a solution it was imperative to have an overview of what others have attempted and learned when confronting similar problems.

It was indicated in most research and generally agreed upon by the scholarly community that the behaviors of minority youth created a much higher probability of becoming HIV infected. Jemmott, et al. (1992) conducted an HIV education/intervention project with minority teens which consisted of an intense five hour seminar on a Saturday. A three month follow up survey indicated a continued awareness of the risk of contracting HIV.

House and Walker (1993) addressed effective HIV/AIDS education by comparing the "bottom up" vs. the "top down" style of

planning. The "top down" style was preferred because it was conducive to more organized planning starting with the master plan and continuing to the evaluation of program results.

Croteau, et al. (1993) evaluation of offered some suggestions for the evaluation of educational/intervention programs which have proven effective in promoting HIV/AIDS literacy. It was suggested that such programs as the educating of group leaders (the "top down" theory), theater presentations and rap music contests all create desired results. The most effective idea in their report was a week-end retreat format where leaders from campus organizations received intense training in the discussion and modeling of appropriate behavior. Additionally, some guidelines were suggested which will help alleviate prejudicial and emotional barriers in program implementation which are worthy of repeating here:

(1) Include target group members as full partners in planning and implementation;

(2) Involve peer leaders;

(3) Include culturally relevant content, media, and settings;

(4) Foster group pride (p. 293).

A very thorough quantitative research study completed by Tudiver (1992) involved 612 gay and bisexual men. After the preliminaries, including establishing the validity of the pre and post surveys, the men were divided into groups which would have one very intense (several hours) AIDS education session and the others placed in sessions which would happen in subsequent weeks. When the study was over, both sets of subjects had showed statistically significant gains in their AIDS knowledge and in their attitudes toward safer behaviors.

Leviton and Valdiserri (1990) published a report in which they addressed the mediating variables which fall into the scheme of implementing HIV/AIDS education programs. Such variables included questioning whether or not health education "occurs without a proper consideration of the forces that are maintaining risky behavior" (p. 63), the question of knowing the facts vs. the attitudes toward changed behavior, and if the education/intervention strategies used were effective and/or appropriate for the targeted group.

In previous HIV/AIDS education projects which were targeted to a specific at-risk groups Kurth and Champoux (1990) completed a community based AIDS outreach program in New Haven, Connecticut.

The community was experiencing a disproportionately high incidence of HIV in females which was presumed to be the result of much intravenous drug use. Phase I of their project showed a statistically significant need for serious HIV/AIDS education and intervention programs. At the time of their writing the plan for the program consisted of a combination of group meetings, printed materials, and some involvement through the local churches.

Another culture specific HIV/AIDS education program was implemented by Carter and Jalloh (1990) in Forsyth County in an effort to reach the migrant community. The program components consisted of meetings at the local migrant center, church/ community seminars, health advisory training, neighborhood clinics which serve as resource points, and technical consultation which includes interpretation services for those migrants unfamiliar with the English language.

Amer-Hirsch (1989) wrote of an HIV awareness program in the New York area which was geared toward young girls. In their sessions, the girls were not only presented factual information but were given opportunities to make AIDS awareness posters, complete paper and pencil activities reinforcing what they have learned, and

even write essays about dealing with feelings when confronted with an AIDS problem (if a friend became ill). When evaluated according to plan, the program showed a 96 percent increase in HIV/AIDS understanding among participants.

Description of Selected Solution

In order to stay within the framework and accomplish the goals of the practicum the writer chose to design a solution which would be presented to the adults in the work setting. It was believed this approach would cause the least resistance in the rather isolated work setting of the writer. Additionally, the "top down" program design had been shown to be more successful than others (House & Walker, 1993; Croteau, et al., 1993).

The writer chose to direct the solution to the adults in the work setting because experience had shown that many parents in this area may be leery of this type of information being presented in school to younger children. Presenting the information in this format allowed for the "top down" theory to work as well as bypass any potential problems with the social discomfort of the information.

Report of Action Taken

The implementation of the practicum took place on two separate campuses where the writer serves as an elementary music teacher. For purposes of simplicity, the primary campus met on Tuesday mornings and the intermediate campus met on Wednesday afternoons.

The practicum sessions were held outside school hours in the media centers of the respective buildings. The writer allocated 30-60 minutes for each and recorded the number of people attending (Table 1). In keeping with the anonymity of the participants, no names were recorded. The sessions were entirely voluntary. Each participant was asked to keep a journal to record thoughts, ideas, reflections or to write down information of particular interest or relevance to them. Sessions 2-12 each began with af reflecting what had transpired in the previous session (or sessions).

In preparation for the first meeting, it became evident that

Table 1

Participant Attendance at Sessions

WEEK	CAMPUS A	CAMPUS B	TOTAL
1	12	7	19
2	5	5	10
3	6	3	9
4	7	5	12
5	8	4	12
6	4	6	19
7	9	4	13
8	11	3	14
9	6	2	8
10	8	4	12
11	0	0	0
12	12	10	22

participation in the practicum would not be as successful if the writer depended wholly on the meetings. At this point the writer altered the effort to allow time for the meetings as originally planned but to supplement and provide for those who were unable/unwilling to attend, the writer prepared a manuscript addressing each topic. For those who did not attend, the weekly manuscript was made available to them.

Week One

During the first week, an overview of the project was presented by the writer which explained why the project was taking place, why the writer was taking the initiative, and the significance of the practicum vs. the traditional dissertation. The pre-questionnaires were distributed to the participants and asked to be returned as quickly as possible. The faculties In both schools were quite enthusiastic about the project and shared comments which indicated their concern regarding the need for a program of this nature. Two different faculty members presented the writer with additional literature which could possibly be used in the project.

Week Two

During the second week of implementation the writer presented the topic and manuscript entitled "The Role of the Child and Youth Professional in the AIDS Crisis" (Appendix C). Essentially, the main idea presented at this time was that in order for Child and Youth Professionals to make a difference it was necessary to simply approach the issue with the utmost in professional objectivity. The major goal must be to save lives while teaching values must be secondary. The manuscript made reference to our nation's blood supply being "virtually 100 percent safe". One faculty member approached the writer and shared a disagreement with that statement as the person was not convinced that every single unit of infected blood is detected and destroyed.

Week Three

The topic during the third week of implementation was "Educational Issues Brought About by the AIDS Crisis: Why the Schools Will Not Respond" (Appendix D). The main idea of this

presentation by the writer and the accompanying manuscript was that schools are not doing enough to make a difference mostly because there is so much controversy as to an appropriate action which must be taken by them. During this week, an English teacher shared with the writer that a student had written in a journal that they believed a person could become HIV infected by working with an infected person or by washing their hands in a common sink. Because the responsibility of schools and teachers is so nebulously defined, the teacher was reluctant to speak to the student to address the concern.

Week Four

During the fourth week of implementation the topic to be addressed was "The Role the Electronic and Printed Media Has Played in the AIDS Crisis" (Appendix E). At this meeting, the writer spoke addressing the topic and presented an accompanying manuscript which was intended to show how the media has distorted the facts and done a very poor job in any effort to educate the public with the information which can make a difference. Several teachers commented to the writer how adamantly they agreed with the writer's

position but had not seen a written presentation addressing the issue. One faculty member, a speech therapist, approached the writer asking permission to use the manuscript in a weekly health awareness class for senior adults which the person was teaching at a local health club.

Week Five

The topic during the fifth week of implementation was "The Role of the Church in the AIDS Crisis" (Appendix F). The purpose of this topic was not to present a particular theological or doctrinal viewpoint but to simply overview what many evangelical and liturgical churches and synagogues have done in response to the AIDS Crisis. The writer presented the literature which was available at the time addressing the topic and shared with the participants some first hand experiences and some experiences shared by other ministerial professionals on the topic. Several comments were received from faculty members thanking the writer for his insight. A districtwide teacher of talented art expressed concern to the teacher over how little these matters are discussed and what a difference can be made by simply discussing issues.

Week Six

The topic for the sixth week addressed the question of cultural boundaries which must be overcome in order for HIV education to be truly effective (Appendix G). Most participants were curious as to how cultural boundaries could filter into effective HIV education but soon realized that the question of group specific must be considered for any program to be effective. The writer spoke to the group sharing what had been determined by the current literature on the topic and presented the accompanying manuscript. Generally, the topic was well received.

Week Seven

The seventh topic in the practicum addressed the issue of separating the facts from the myths about HIV and AIDS (Appendix H). Many participants held some beliefs based on serious misinformation such as HIV being transmitted through a mosquito bite, a fetus being infected in the womb of an infected mother, the

populations most at risk, and the bodily fluids which epidemioloqists know transmit the virus. The writer spoke to the group presenting a brief overview of the manuscript and allowed a time of general discussion. Most of the participants were receptive to the information and its origin but some were skeptical. Comments were made by some of the participants such as, "The medical community is not telling us everything about this. They're telling us what they want us to know" or "I don't believe a lot of what I hear. I'm still nervous about using public restrooms". Still, the information was presented with the appropriate documentation so that the participants could make appropriate decisions in their own lives.

Week Eight

The topic for the eighth week of implementation was the issue of teens and AIDS (Appendix I). The session was not a formal lecture but simply a casual, interactive time of discussion.

Although the fact that teens aree the segment of the population in which the spread of HIV was the most rampant is a fact that had eluded many of the participants during the pre-questionnaire stage of

the implementation, most were not surprised to learn otherwise. Interestingly, the writer was subsequently approached by a colleague (not a participant in the practicum) and was told that this colleague had an eighth grade student who was pregnant. The colleague reported the student had "been trying to get pregnant for some time with various boyfriends." This incident made the writer aware of how real statistics can be.

Week Ten

Safe behavior (Appendix J) was the topic for the 10th week of implementation. The writer informally presented an overview of the accompanying manuscript and allowed time for informal discussion, questions, etc. Among the participants the question of safety in the workplace around children seemed to be of more importance than safety in sexual behaviors. (Most of these people were married and would not likely fall into a high risk group relative to sexual responsibility or the lack thereof.) Some discussion ensued concerning, "Should I put on gloves just to put on a band-aid?". One secretary told that when she is called upon to bandage an injured

student she puts on the latex gloves but has the student do as much of the cleaning and bandaging of the wound as possible. This participant stated that although not coming into direct contact with blood would probably not create a risk factor, it still created a risk factor which this participant was not willing to take. A principal informed the writer that it was suggested that speech pathologists wear gloves when working with speech impaired children which necessitates the manipulation of their lips, etc. While medical data says saliva absent of blood poses no inherent risk, the practitioner must ask if this is a risk factor they are willing to assume. The common consensus among the participants seemed to be that in all matters, common sense should prevail.

Week Eleven

The 11th week of the implementation fell at a time in which a holiday which is culturally relevant to the state was occurring. The writer was disappointed but not surprised when not one person attended the meeting(s). Subsequently, the writer made copies of the manuscript entitled "Does Education Help in Modifying Risky

Behaviors?" (Appendix K) and made them available to all participants.

Week Twelve

During the 12th and final week of the implementation the topic was entitled "What Teachers Need to Know to Make a Difference" Appendix L). After discussing the contents of the manuscript the writer presented each teacher with a list of resources for continuing to be abreast of correct AIDS information. Each participant was presented with the symbolic red AIDS Awareness Ribbon which was attached to a card bearing the following statement:

> The simple red ribbon has become a symbol of AIDS awareness. The red is symbolic of lives lost. The safety pin is a reminder of those safe behaviors which we know save lives by preventing the spread of HIV.

CHAPTER V

The problem addressed in this practicum was that adults in the work setting were not provided with appropriate information which would allow them to adequately discuss the current level of information about HIV/AIDS with children and youth. The solution strategy utilized was an awareness program the adults AIDS literate.

Results

At the proposal stage of the practicum there were to be 44 participants. By the implementation phase two student teachers from a local university had joined the faculty and were therefore included in the practicum. In the calculation of the data they were included with those who held a bachelor's degree as they were only within weeks of degree conferral.

The measurement of success for this practicum was determined by the use of a writer-prepared pre-questionnaire and post-questionnaire. The pre-questionnaires consisted of four sections

which included demographic data, mode of transmission information, HIV/AIDS education information, and society at risk information. Of the 46 participants, six reported to have attended but not completed college, 23 reported to hold a bachelor's degree, and 17 reported to hold a masters's degree or higher.The scores of the participants according to the level of education are reported in Table 2.

Table 2

Average of Participant's Scores Based on Level of Education

GROUP	MODE/TRAN	HIV ED.	AT RISK	AVERAGE
Some college	60%	71%	35%	55.3%
B.A. degree	73%	71%	64.3%	69.4%
M. Ed. degree	70.2%	69.4%	51.7%	63.7%
Master's degree plus	69.8%	67.3%	52.1%	63.06%
TOTAL/ AVERAGE	68.25%	69.68%	50.78%	62.9%

The pre-questionnaires were scored and each section was averaged. The results of the pre-questionnaires are shown in Table 3.

Table 3

Average of Participant's Scores on Pre-Questionnaire

MODE OF TRANSMISSION	HIV EDUCATION	AT RISK GROUPS	TOTAL/ AVERAGE
68.25%	69.68%	50.78%	62.9%

Of the 46 participants, 17 reported to have known someone with HIV or AIDS. The scores of the participants who had and had not known someone with HIV or AIDS or who have had their life significantly affected by AIDS were averaged. These findings are reported in Table 4

Table 4

Average of Participant's Scores Based on Having Known or Not Known Someone With HIV or AIDS

GROUP	MODE/TRAN	HIV ED.	AT RISK	AVERAGE
Have known someone	71.4&	72.1%	70.0%	71.18%
Have not known someone	65.1%	67.26&	31.52%	54.6%
TOTAL/ AVERAGE	68.25%	69.68%	50.78%	62.90%

Several specific/behavioral outcomes were stated in the proposal. The success of the outcomes was determined from the writer prepared post-questionnaire. These findings are presented in Table 5.

At the conclusion of the implementation phase of the practicum the writer prepared post-questionnaire was distributed. The scores were averaged and are presented in Table 6.

Table 5

Specific Objectives Met

OUTCOME	PARTICIPANTS	SUCCESSFUL	UNSUCCESSFUL
Transmission Knowledge	46	35	11
Body fluids	46	41	5
Prevention	46	40	6
School failure	46	42	4
Media	46	45	1
Churches	46	41	6
Increase effect	46	41	5
Teen info	46	44	2
Safety/ personal	46	46	0
Policy response	46	39	7

Table 6

Average of Participant's Scores on Post-Questionnaire

MODE OF TRANSMISSION	HIV EDUCATION	AT RISK GROUPS	TOTAL/ AVERAGE
89.8%	88.43%	95.55%	91.26%

An explanation of the goals and expectations is as follows:

The primary goal of this practicum was to provide adults with information which would allow them to accurately discuss the current level of information about HIV/AIDS with children and youth. Being adequately prepared with the correct information will allow them to alter their behaviors accordingly and will make them a source of information and/or a risky behavior deterrent for children and youth.

At the conclusion of the practicum the writer expected to see adults appropriately prepared to provide factually correct information regarding the prevention of HIV/AIDS to children and youth. The writer expected adults to separate the facts from the rumors regarding the HIV/AIDS crisis in an articulate manner. The writer would see child

and youth professionals verbalize why AIDS is a teenage problem and why the schools are unable to respond in an appropriate or effective manner. The writer would observe fellow child and youth professionals defining their role in the AIDS crisis. Based upon the observations and data generated by the writer during the implementation phase of the practicum, the writer can assert that these goals, expectations, and outcomes were met.

In addition, the writer expected to see several specific outcomes. These were achieved as follows:

(1) It was expected that 75 percent (33 of 44) of the adults would correctly list five ways in which HIV is transmitted. Thirty-five participants achieved this outcome while 11 did not.

(2) It was expected that 75 percent (33 of 44) of the adults would correctly identify the four bodily fluids which are known to transmit HIV. Forty-one participants achieved this outcome while five did not.

(3) It was expected that 75 percent (33 of 44) of the adults would list 5-10 methods of preventing the spread of HIV. Forty participants achieved this outcome while six did not.

(4) It was expected that 75 percent (33 of 44) of the adults would state three reasons our schools have failed in making a contribution to effective HIV education. Forty-two participants achieved this outcome while four did not.

(5) It was expected that 75 percent (33 of 44) of the adults would state 2-3 ways in which the electronic and printed media have misrepresented the facts and/or misinformed the public in the AIDS crisis. Forty-five participants achieved this outcome while one did not.

(6) It was expected that 75 percent (33 of 44) of the adults would list several ways in which the churches have responded to the AIDS crisis. Forty-one participants achieved this outcome while five did not.

(7) It was expected that 75 percent (33 of 44) of the adults would list four attributes of an HIV/AIDS education program which are known to increase effectiveness. Forty-one participants achieved this outcome while five did not.

(8) It was expected that 75 percent (33 of 44) of the adults would state 3-5 reasons the teen poulation is a such a risk

for infection. Forty-four participants achieved this outcome while two did not.

(9) It was expected that 75 percent (33 of 44) of the adults would state at least five ways to keep themselves risk free in an emergency situation which may put themselves at risk for infection. All 46 participants achieved this outcome.

(10) It was expected that 75 percent (33 of 44) of the adults would list 2-3 ways in which policy makers can effectively respond to the AIDS crisis at their level. Thirty-nine participants achieved this outcome while seven did not.

Discussion

It was proposed that the writer would accept a 25 percent increase between the scores on the pre- and post- questionnaire as successful. From the data presented, the writer can assert that the practicum was definitely successful.

While not calculated and reported numerically, there were several interesting details noticed by the writer during-g the

implementation phase of the practicum. First, 17 out of 46 participants (more than one-third) reported to have not known someone with HIV or AIDS. This lack of knowledge could be attributed to the type of work or the lifestyles of the participants.

All participants in the practicum had at least attended college. Only six did not actually hold a college degree. With a sample of this type, the writer finds it interesting that so much misinformation seemed to exist.

An informal look through the pre-questionnaires indicated that many educated adults seemed to hold beliefs such as HIV being transmitted by mosquito bites or that a fetus cannot be infected while in the womb of an infected mother. Such misinformation can possibly be attributed to the presentation of distorted facts or partial truths by the media. Regardless, the writer found it interesting that college educated people would report such beliefs for whatever reason.

The greatest area of misinformation among the participants in this practicum was the population in which the transmission of HIV is the greatest. Many reported the population to be most at risk as both homosexuals and IV drug users. Any number of factors could attribute to this error.

During the implementation of the practicum, the writer became even more aware of how few programs of this nature are in place and how great the need for HIV education at the adult level is. The writer has likewise come to realize how complacent many in positions of leadership have been in making an effort to curtail the spread of HIV and AIDS. The writer has a clear mental picture of where the threat of HIV and AIDS falls in the scope of national priorities.

Recommendations

In an effort to repeat this project in another work setting, this writer would make the following recommendations:

(1) In a traditional school setting, begin the project at such a time that it is not interrupted by vacation.

(2) Consider the work setting and the local population in order to include some parents It is believed that parents can benefit from the practicum experience as well as those in professional positions.

(3) Consider including all adults in the work setting, not just those in professional positions. Even the adults in the

work setting who are not in a position of direct leadership of children can become proponents of proactive change.

Dissemination

The writer has disseminated the practicum in several ways. The school district in which the writer is employed agreed to duplicate and bind copies of the completed project so that it may be placed in every school in the district. As such, the writer will be available as a resource for presentations or simply to explain the components of the practicum.

. Finally, the writer was approached by a Professor of Pediatrics from the Louisiana State University School of Medicine asking for the completed practicum (Appendix N).

Copies of the completed project will be placed in two schools in which the writer has previously served as a teacher. The writer made contact and offered to present the project to the local Big Brothers and Big Sisters of America organization.

At the time of this writing, the project was being prepared for a conference presentation.

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APPENDIX A

PRE-PRACTICUM QUESTIONNAIRE

An HIV Awareness Program for Adults:
Increasing The Awareness of Child and Youth Professionals in the AIDS Crisis

Pre-Practicum Questionnaire

Please be assured that the information requested here is designed not to be personally identifiable.

Your age:_____ Male_____ Female_____

Have you heard of AIDS (Acquired Immune Deficiency Syndrome)? Yes_____No_____

Do you know or have you known someone with HIV or AIDS? Yes_____ No_____

What is your level of education?

Less than high school	_____
High school	_____
Completed some college	_____
Hold bachelor's degree	_____
Hold master's degree	_____
Hold doctoral degree	_____
Other	_____

How do you think people catch AIDS?

- sharing drug paraphernalia	Yes_____	No_____
- unprotected heterosexual sex	Yes_____	No_____
- receiving blood at a hospital or clinic	Yes_____	No_____
- from a toilet seat	Yes_____	No_____
- from deep kissing	Yes_____	No_____
- unprotected anal sex	Yes_____	No_____
- donating blood at a hospital or clinic	Yes_____	No_____
- unprotected oral sex	Yes_____	No_____
- unprotected homosexual sex	Yes_____	No_____
- drinking from a public water fountain	Yes_____	No_____
- baby gets it from the mother	Yes_____	No_____
- shaking hands	Yes_____	No_____
- unprotected sex with an IV drug user	Yes_____	No_____
- getting bitten by a mosquito	Yes_____	No_____
- what else?_____		

How can a person lower their chances of becoming infected with HIV?

- decrease number of sexual partners	Yes_____	No_____
- use a condom during sex	Yes_____	No_____
- only have sex with people who look healthy	Yes_____	No_____

- don't share needles with anyone Yes_____ No_____
- remain faithful to one sexual partner Yes_____ No_____
- avoid contact with blood or any bodily fluids which are known to transmit HIV Yes_____ No_____
- what else?_____

Where should children learn about sex?
- Health Facility Yes_____ No_____
- School Yes_____ No_____
- Family Yes_____ No_____
- Friends Yes_____ No_____
- TV/Radio Yes_____ No_____

Where is the best place for people to learn about HIV and AIDS?
- Health Facility Yes_____ No_____
- School Yes_____ No_____
- Family Yes_____ No_____
- Friends Yes_____ No_____
- TV/Radio Yes_____ No_____
- Church Yes_____ No_____
- Other?_____

What is the segment of society in which the transmission of HIV is the greatest at the present time?
- Homosexual males _____
- Homosexual females _____
- Prostitutes _____
- Minorities _____
- Teens _____
- IV drug users _____

Note. Adapted from "Community-Based Outreach for AIDS Education in New Haven, Connecticut" by Ann Kurth, 1988, Connecticut: Yale School of Nursing.

APPENDIX B

POST-PRACTICUM QUESTIONNAIRE

An HIV Awareness Program for Adults:
Increasing The Awareness of Child and Youth Professionals in the AIDS Crisis

Post-Practicum Questionnaire

Please be assured that the information requested here is designed not to be personally identifiable.

Your age:_____18-25
_____26-35
_____36-45
_____46-55
_____56-65
_____65 +

Male_____ Female_____

Do you know or have you known someone with HIV or AIDS?
Yes_____ No_____

What is your level of education?

Less than high school	_____
High school	_____
Completed some college	_____
Hold bachelor's degree	_____
Hold master's degree	_____
Hold doctoral degree	_____
Other	_____

How do you think people catch AIDS?

- sharing drug paraphernalia	Yes_____ No_____
- unprotected heterosexual sex	Yes_____ No_____
- receiving blood at a hospital or clinic	Yes_____ No_____
- from a toilet seat	Yes_____ No_____
- from deep kissing	Yes_____ No_____
- unprotected anal sex	Yes_____ No_____
- donating blood at a hospital or clinic	Yes_____ No_____
- unprotected oral sex	Yes_____ No_____
- unprotected homosexual sex	Yes_____ No_____
- drinking from a public water fountain	Yes_____ No_____
- baby gets it from the mother	Yes_____ No_____
- shaking hands	Yes_____ No_____
- unprotected sex with an IV drug user	Yes_____ No_____
- getting bitten by a mosquito	Yes_____ No_____
- what else?_____	

How can a person lower their chances of becoming infected with HIV?

- decrease number of sexual partners Yes_____ No_____
- use a condom during sex Yes_____ No_____
- only have sex with people who look healthy Yes_____ No_____
- don't share needles with anyone Yes_____ No_____
- remain faithful to one sexual partner Yes_____ No_____
- avoid contact with blood or any bodily fluids which are known to transmit HIV Yes_____ No_____
- what else?_____

Where should children learn about sex?

- Health Facility Yes_____ No_____
- School Yes_____ No_____
- Family Yes_____ No_____
- Friends Yes_____ No_____
- TV/Radio Yes_____ No_____

Where is the best place for people to learn about HIV and AIDS?

- Health Facility Yes_____ No_____
- School Yes_____ No_____
- Family Yes_____ No_____
- Friends Yes_____ No_____
- TV/Radio Yes_____ No_____
- Church Yes_____ No_____
- Other?_____

What is the segment of society in which the transmission of HIV is the greatest at the present time?

- Homosexual males _____
- Homosexual females _____
- Prostitutes _____
- Minorities _____
- Teens _____
- IV drug users _____

Which of the following is known to contribute to the success of an HIV/AIDS education program? (Check all that apply.)

- group specific presentations _____
- presentations presented in same jargon and vernacular as the at risk group _____
- programs which calmly present the facts _____

- programs which separate the facts from the myths _____
- programs in which the participants are involved in the learning outcomes _____

Which of the following bodily fluids is known by epidemiologists to transmit HIV?

- blood _____
- saliva _____
- semen _____
- sweat _____
- breastmilk _____
- vaginal secretions _____
- tears _____
- urine _____

Which of the following are ways in which the electronic and printed media have misrepresented the facts and/or misinformed the public in the AIDS crisis?

- only reporting partial statistical information _____
- reporting only the statistics and/or facts which will most likely sell the story _____
- not putting the statistical findings in their proper perspective _____
- all of the above _____

Which of the following are reasons the schools have failed in making a difference in the AIDS crisis?

- Schools are under such immense pressure for accountability _____
- There is little agreement among social science and education professionals as to an appropriate response to the AIDS crisis _____
- The schools are so carefully scrutinized that policy makers are reluctant to broach controversial topics _____
- Most public school administrators are complacent and don't care _____
- Adults have not been adequately prepared with correct HIV knowledge _____

Which of the following are ways in which the churches have appropriately responded to the AIDS crisis?

- Throwing out members whom they suspect may have HIV or AIDS _____
- Embracing the doctrine of "hating the sin but loving the sinner" _____
- Working with other congregations and agencies to assist those in need as a result of AIDS _____

WHich of the following are ways in which child and youth professionals can keep themselves free of risk when in a situation which may pose some risk?

- Do not allow yourself to come into contact with any bodily fluids of children._____
- Do not allow children to cough on you or sneeze in your direction _____
- Always wear rubber gloves if you must touch a child who is wounded or having a nosebleed _____
- Don't hug children _____

What can policy makers do to effectively respond to the AIDS crisis at their level?

- Work to implement programs which will educate the public at large _____
- Be receptive to the culture-specific needs of certain groups within society _____
- Not worry because AIDS only happens to unimportant people _____

Why is the teen population more at risk for HIV infection than other segments of society?

- Teens have more promiscuous sex than adults _____
- The media portrays a carefree sexual lifestyle as healthy and/or desirable _____
- There are relatively few truly effective HIV education programs geared to teens and youth _____
- Many teens still perceive HIV and AIDS as a homosexual problem _____
- All of the above _____

Note. Adapted from "Community-Based Outreach for AIDS Education in New Haven, Connecticut" by Ann Kurth, 1988, Connecticut: Yale School of Nursing.

APPENDIX C

THE ROLE OF THE CHILD AND YOUTH PROFESSIONAL IN THE AIDS CRISIS

THE ROLE OF THE CHILD AND YOUTH PROFESSIONAL IN THE AIDS CRISIS

A considerable body of research has been generated in the last ten years dealing with the most frightening medical and social dilemma in history, Acquired Immune Deficiency Syndrome, or AIDS. What began in the late 1970's as a controversial trauma to the homosexual community has spread rapidly into other segments of society including children. Various amounts of research indicate that the most rampant transmission rate of the disease is among heterosexual teenagers, particularly minorities. As this will inevitably be a problem that schools and other child and youth agencies will be forced to confront, our society needs leaders with the vision to face this crisis with plans, programs and policies to meet the seemingly insurmountable needs of children and youth with HIV/AIDS. The top priority for child and youth professionals, however, should be prevention rather than intervention simply because intervention is too late.

AIDS and Schools

Up to this point the schools, both public and private, and other child and youth agencies have had relatively little to deal with in children and youth infected with HIV or AIDS. The cases of Ryan White and more recently Ricky Ray in Orlando, Florida, were isolated, well-publicized instances in which the youngsters were exposed to HIV through a tainted blood transfusion. Now that the nation's blood supply is virtually 100% safe it stands to reason that children and youth infected with HIV will have been exposed through some type of accidental exposure, been born infected, or exposed through sexual contact or drug use.

Educators and other child and youth professionals have long struggled with the question of where their professional roles fit in the AIDS crisis. Kaplan and Springen (1991) wrote that the ACLU filed a lawsuit against a Wisconsin school system for teaching sex education classes from a point of view whereby "boys and girls sexual behaviors were stereotyped, birth control frowned upon, AIDS characterized as a statement on sexual behavior, and the two-Parent heterosexual family considered to be the only model of healthy family". Most educational

institutions face the obstacle of teaching sex education that is free of values, morals or cultural bias because the general public is in disagreement as to the appropriate manner of presenting AIDS information to youngsters. It is often argued that AIDS prevention presented as anything other than sexual abstinence is only encouraging youngsters to experiment.

Teens at Risk

A large amount of research indicates that the socio-sexual behavior of youth and adolescents create different margins for risk than that of adults. Weiner (1986) reports that the average person becomes sexually active at age 16. Gibbs (1991) says that by junior high school 61% of the boys and 47% of the girls have engaged in sexual intercourse.

Various research has indicated a greater risk factor for ethnic minority adolescents than white adolescents. Gardner, Millstein, and Wilcox (1990) report that "the onset of sexual activity is earlier in males than females, earlier in black adolescents, and earliest in black males" Among persons ages 13-19 who have been exposed to HIV the

female/male ratio is 3:1.

Other societal factors which seem to create a greater risk among teens are the social pressures placed on them and the acceptance of behaviors which until recent years would not have been allowed or tolerated. According to Gelman (1990), teens today are facing adult-like stress at a much earlier age than in previous years. The breakup of families, money shortages, and child care necessities cause many to fill roles and accept responsibilities ordinarily expected of adults. Waldman and Springen (1992) report that 74% of high school juniors work an after school job either to supplement family incomes or provide clothes and personal effects for themselves. The same report shows 84.5% of teenagers dating regularly. Zeman (1990) states that "teens are dating younger, paying more and tumbling into the back seat quicker"

Common sense dictates that the more frequently risks are taken, the more likely they are to fall prey to misfortune. Another controversial factor contributing to an increased risk of HIV/AIDS in teens is the apparent acceptance of an inherent homosexual inclination in adolescents. Recent medical research has indicated differences in the genetic and chemical make-up of heterosexuals and homosexuals

lending credence to what many counseling psychologists are seeing: teenagers who claim to be struggling with an inseparable homosexual tendency. Although social scientists discuss this issue much more today than in past years it is hardly something new. Kinsey, Fomeroy, and Martin (cited in Weiner, 1986) wrote as early as 1948 that homosexual activity among men "is much more frequent than is ordinarily realized." The electronic and printed media today are bombarded with stories of teenagers coming to terms with their homosexuality in the age of AIDS. Baker (1990) wrote that "adolescence is never easy, but growing up gay has always been trying". Feeling socially ostracized often makes the seeking of AIDS prevention information a low priority.

Teens and AIDS Education

With all that we do know about AIDS and the teenage community it is especially alarming what the teenage community does not know about AIDS. DuRant, Ashworth, Newman and Gaillard (1991) conducted a research study to measure what high school students know about HIV/AIDS and the risks involved. More than 50% of the

subjects studied were mistakenly informed that HIV/AIDS can be transmitted through such means as mosquito bites, donating blood and using public toilets. Male subjects studied had less AIDS knowledge than females, Hispanics less than non-Hispanics,and black subjects had less knowledge than white subjects. Subjects with some formal HIV/AIDS instruction had more AIDS knowledge than those with no formal instruction. With such discrepancies in what teens know about AIDS and its prevention, some bold, standardized educational strategies are critical.

The schools have repeatedly made certain mistakes in the presentation of intervention programs for other "crisis" type situations. Smith (cited in Weiner, 1986) stated that educational programs which focus on a crisis were generally no more effective than any other curriculum that was well planned, sequential, and incorporated as part of the school's regular curriculum. Additionally, educators frequently have such rigid guidelines imposed on them by those who do not wish to make anyone uncomfortable by their programs that the programs lose their focus and purpose. This type of counterproductive behavior is what Senge (1990) would refer to as "the learning disability within an organization."

In reference to drug education Lawrence (cited in Weiner, 1986) stated that most class discussions do not explicitly say that drug use can be fatal. Instead, drug educators try to clarify "values" without pinpointing inevitable consequences. According to DuRant et al. (1991) a direct correlation exists between correct AIDS information and decreased risk-taking behavior.

Conclusion

It is the opinion of this writer that an aggressive (not harsh), visionary type of leadership with no regard for emotional attachments is needed to identify the role of the child and youth professional in the AIDS crisis. Heider (quoted in Rosenbach & Taylor, 1982) strongly cautions against harsh interventions as they are usually more detrimental than helpful. Rather the role in question is one of educational professionals, agency or social workers, or those called to the ministry, only this calibre of leadership will ensure that the same mistakes are not repeated as in previous drug or other crisis intervention programs which have proved virtually ineffective. Goal-oriented leaders must confront this crisis knowing that factually

correct information must be presented without regard to morals, sexuality, or the degree of social discomfort caused by the presentation of facts. Effective, insightful leaders will differentiate between sexual education, birth control education, and AIDS prevention education. If the social discomfort of dealing with the facts of AIDS or the subject of sexuality interfere with saving lives, they must be considered a second priority. Senge (1990) discusses the "structure influences behavior" theory with structure meaning "key interrelationships which influence behavior (p. 44). Rather than allowing the crisis to dictate how child and youth professionals should behave/respond (structure influencing behavior), they should direct their efforts toward the underlying causes which create disproportionately higher HIV/AIDS risk factors for teens (behavior influencing structure).

While much of the hysteria of the mid 1980's has dissipated there are still many gross misrepresentations of facts floating among the general population. Until those professionals entrusted with children and youth push past the inhibitions the crisis will escalate. According to G. Peck (personal communication, Feb. 21, 1993), each day in the state of Louisiana four high school students become HIV

positive. While medical research in AIDS treatment is progressing rapidly and we see new breakthroughs every day, most AIDS experts agree that "education is the only vaccine we have now."

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APPENDIX D

EDUCATIONAL ISSUES BROUGHT ABOUT BY THE AIDS CRISIS: WHY THE SCHOOLS WILL NOT RESPOND

EDUCATIONAL ISSUES BROUGHT ABOUT BY THE AIDS CRISIS: WHY THE SCHOOLS WON'T RESPOND

Background

When the AIDS crisis surfaced in the early 1980's, few could have envisioned the awkward and painful dilemma the schools would face. It is clearly evident that the schools have not effectively responded to the AIDS crisis mostly as a result of two opposing schools of thought which dominate throughout the school systems. The liberal voices are saying "If we don't take charge, no one will" while the conservative voices are saying "It's not our responsibility to teach about these sensitive things." This report is not intended to assume a liberal or conservative position but to serve as an overview of the conflicts which have impeded and deadlocked any contribution(s) the schools should be making in the fight against AIDS. Except where expressly stated, the information in this report is not necessarily the opinion of the writer.

AIDS Education and Schools

At any professional level (education, child and youth, medical, legal, ministerial,etc.) any type of HIV/AIDS education up to this point has been a question of "How much can we say and how far can we go?" Educational and child and youth professionals, not unlike any others, often exhibit behaviors which are inherently self-defeating and impede progress in any endeavor.

It is certainly no secret that our schools are notorious for "jumping on a bandwagon" because someone in another state said it was a good idea, often with little or no forethought or long term effects considered. In the same manner in which Shilts (1987) describes the lack of effort on the part of the government and medical community in the early stages of the AIDS epidemic, our schools are just as notorious for doing nothing for the majority for fear of repercussion from a small minority.

Many educational writers have harshly challenged the schools to begin doing their part in battling the AIDS crisis. Popham (1993) states:

> I believe that the efforts of America's educational leaders to combat the HIV epidemic are comparable to trying to put out a raging house fire by flicking it with a wet toothbrush (p. 559).

Popham further cites causes which disallow any effective prevention education on the part of the schools. Dealing with such a crisis at the school level is a "new phenomenon" (p. 559). There has never before in history been a health issue of this magnitude in which the only prevention was education. Many educators at the policy making level do not truly understand the seriousness of the educational intervention which is needed to deter the risky behaviors practiced by children and youth. Popham states:

> Working against biological drives and culturally approved practices, an AIDS education program that consists of just a few hours of factual information will have little or no impact on adolescents' sexual behaviors. Research evidence shows us that knowledge alone won't do the trick when it comes to modifying young people's high-risk behaviors. Even adding scare tactic

> admonitions about the perils of HIV infection won't fill the bill. Altering the sex-related behaviors of young adults is unbelievably difficult (p. 560).

Finally, Popham cites as a deterrent to effective HIV education the fact that many school administrators are reluctant to take on one more instructional responsibility. While the need is clearly dictated by common sense educational leaders generally do not want to embark on projects which do not produce a standardized measurable outcome. Also, school administrators must, by necessity, exercise extreme caution in implementing programs which may evoke a negative response from parents, community members, or anyone else to whom the schools are at least indirectly accountable.

Iverson and Popham (1993) published a report calling for very aggressive standards in school level HIV education. The contention of these researchers is that HIV programs should focus on the absolute facts, apart from any type of "values clarification". Additionally, their report calls for significant amounts of class time consistently used for HIV education on the part of students and teachers.

What Can the Schools Do?

Many writers have offered opinions and ideas as to what would constitute effective HIV/AIDS education These ideas have ranged from subtle efforts on the part of teachers to a more aggressive effort from those on the outside. The following broad suggestions have been discussed the most frequently.

There Must Be Some Consistency in Planning Programs

Slavin (1989) accuses our schools of adopting programs which have not been adequately field tested or which have no data supporting their effectiveness other than being "new" or "based on research". An informal glance around the school districts will show a multitude of programs which were enthusiastically adopted and quietly put aside. The right amount of "professional homework" must be done before anyone can expect any HIV/AIDS education program to meet the needs of the children in question.

The Programs Must Address the Crisis, Not Generate Hysteria

According to Smith (cited in Weiner, 1986), educational programs which focus on a crisis type situation are generally no more effective than any other program which is well planned, sequential, and incorporated into the school's regular curriculum. These same mistakes have been made for many years in drug education programs which attempt to clarify "values" rather than pinpointing inevitable consequences.

Programs Must Present Information Which Is Usable

It is the position of Iverson and Popham (1993) that HIV education programs must motivate children to eliminate the risky behaviors by clearly showing which behaviors actually put them at risk for infection. Iverson and Popham also call for the use of normative data which would provide a more accurate depiction of what people really do.

Conclusion

The question of the school's response to the AIDS crisis is one which is not easily answered. It appears from the information available that the question is not whether or not the schools should respond, but the manner in which they should respond. Again, a comparison is made between the current behaviors of educational leaders and behaviors of medical/ governmental leaders in the early days of the AIDS epidemic - particularly that of Dr. Robert Gallo. According to Shilts (1987) Dr. Gallo, a prominent AIDS researcher was successful in isolating the virus at about the same time as some French researchers at the Pasteur Institute. The question of who actually discovered the virus had to be settled via litigation before any further research could continue. Consequently, the development of a test for the HIV antibodies was significantly delayed.

It is the opinion of this writer that the schools must not find themselves in a similar predicament arguing over ownership while anything beneficial is lost. The schools are charged with an awesome responsibility in facing a health epidemic unlike any throughout history. Delaying progress over semantics is futile.

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APPENDIX E

THE ROLE THE ELECTRONIC AND PRINTED MEDIA HAS PLAYED IN THE AIDS CRISIS

THE ROLE THE ELECTRONIC AND PRINTED MEDIA HAS PLAYED IN THE AIDS CRISIS

In the midst of the most heinous health crisis in history it is imperative that the general public be informed as to the most current and accurate information concerning the transmission and prevention of AIDS. Although our society is one of the more "schooled" in the world it is a fact that we get most of our information not from reading but from the mass media. While journalistic efforts in our country are generally honorable and certainly accountable to standards of ethics and accuracy there is no question of the power of the media to shape our thinking and skew our viewpoint. This report is not intended to berate the efforts of the media but to provide an overview of how the media often influences the public's perception of the realities in the AIDS crisis.

Media Distortion of Information

Unlike the printed media, the electronic media does not have the luxury of whatever time and space is needed to present the desired information. Consequently, much of the information presented is simply a compilation of the facts which an editor deems important. While the average person in the viewing public does not necessarily need any formal training in statistics to interpret what the media says, it should be any adult's responsibility to become an informed consumer of information.

The media frequently reports numbers with no information to validate those numbers. To say that "x" number of people have died doesn't tell us a great deal in terms of the total picture of the AIDS crisis. Lynch (1993) puts some of the AIDS hysteria in perspective by comparing AIDS to other health related issues. Among his citations are the fact that Americans are 36 times more likely to die of cardiovascular disease than of AIDS. Likewise, Americans are 16 times more likely to die of cancer than of AIDS. If these numbers were calculated statistically, they would probably be somewhat low because

of the awareness factor for AIDS that is generated by the media which is not generated for other health care issues.

Winnett, et al. (1990) confronted the media and their contribution to effective AIDS education to pinpoint where they have succeeded and failed. Their research has shown that many segments of the population must hear that "you do this and don't do that" to keep yourself healthy. It is their position that simple presentation of the facts is more effective than some scare tactics.

Literate Consumers

The average American consumer of information must become literate of the facts about the transmission and spread of HIV and AIDS. Perhaps the best place not to learn the facts is from the electronic media. The public must learn to glean from the media what is relevant to them and dismiss what is hype, hysteria, and heresy.

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APPENDIX F

THE ROLE OF THE CHURCH IN THE AIDS CRISIS

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Background

When a mysterious disease surfaced in the early 1980's which baffled the medical community it appeared to be isolated to one small segment of society, particularly homosexual males. It was some time before the medical community coined the acronym AIDS to officially name the disease. Even the very educated and scholarly of society had no idea that the disease would so quickly find its way into the mainstream of society. Very few could have conceived the impact that the AIDS Crisis would make on our churches. This report is not intended to present a theological or doctrinal viewpoint but to serve as an overview of how many evangelical and liturgical churches have responded to the AIDS Crisis.

The AIDS Crisis creates a particularly awkward situation for churches today for two reasons:

(1) When the disease first surfaced it appeared to be isolated among one segment of society whose sexual behavior is generally frowned upon by conservative congregations.

(2) Although the medical community has confirmed that the disease is not transmitted by only one type of sexual behavior, it is known that transmission does occur as a result of other behaviors which are considered less than "moral" by most conservative congregations.

In short, the onset of AIDS in mainstream society was a problem which caught the churches by surprise and presented issues and problems which had never before been confronted. Churches were asking certain questions for the first time and possibly facing the need to re-think some of their traditional teachings. Among theologically conservative congregations, responses to the AIDS Crisis have ranged from the "horror story" to the ultimate in compassion. Giles (1992) writes of a third generation Southern Baptist minister who learned in 1985 that his wife had been exposed to HIV through a tainted blood transfusion and consequently, both of their children had been infected

in the womb. At the time of Giles's writing, the man had been dismissed from his ministerial position, was shunned by several other churches in which he sought membership, and was even asked by some to conceal his wife and children's condition. Eventually, he quit the ministry entirely and began work in counseling.

From the other perspective, this writer served as a minister of music in a large, suburban evangelical church in the late 1980's. It became known among the congregation that a member of the music staff was caring for his life partner who was in the final stages of AIDS. The congregation was absolutely supportive of the man, assisted in any way possible with the needed care, and was never once judgmental of the unfortunate, tragic circumstances. When the man's partner eventually died, the congregation was more supportive than ever by making it clear that the love they extended was not conditional.

Rethinking Tradition

Many writers and religious leaders are challenging churches to reconsider traditional teachings which are not necessarily scripturally

based. According to Drane (1991) many leaders in the Catholic church are finding it necessary to be less dogmatic on the traditional Catholic position on condom use as a means of birth control. He states:

> One approach to the moral question is to bring into play the classical principle of the double effect; ...For persons infected with the AIDS virus, the act of protecting a partner from deadly harm is a right act which has two effects. ...Achieving these ends through condom use prevents conception as well as infection (p. 190).

Many Catholic officials were outraged when the following appeared in a statement by the United States Catholic Conference:

> In such a situation, educational efforts, if grounded in the broader moral vision outlined above, could include accurate information about prophylactic devices or other practices proposed by some medical experts as a potential means of preventing AIDS. We are not promoting the use of prophylactics, but merely providing information that is part of

the factual picture. Such a factual presentation should indicate that abstinence outside of marriage and fidelity within marriage are the only morally correct and medically sure ways to prevent the spread of AIDS (p. 191).

The Churches Respond

As conservative, evangelical churches have faced the AIDS Crisis and been forced to make unprecedented decisions many are abandoning their traditional, dogmatic view of "worldly behaviors" and embracing the doctrine of "hating the sin but loving the sinner." Jones (1993) states,

> We, the church, have the opportunity to demonstrate, in our words and in our lives, God's love for the homosexual person. If we truly love, we will act on that love. We must start by eradicating our negative responses to homosexual people. Stop the queer jokes and insults; they hurt others. We must deal with our own emotional reactions; we must decide to love. We must repudiate

> violence and intolerance toward homosexual orientation. We must change the church so that it is a place where those who feel homosexual desire can be welcomed. The church must become a sanctuary where repentant men and women can share the sexual desires they feel and still receive prayerful support and acceptance (p. 25).

Stafford (1993) writes of a conservative evangelical minister in the midwest who felt compelled to lead his congregation toward a ministry to people with AIDS. The congregation was supportive of their pastor in his viewpoint that while theology may dictate certain scriptural values, it is spiritually inappropriate to stand in judgement of any individual. In reference to the success of his ministry, the pastor stated,

> If the church gets overrun with homosexuals, that will be terrific. They can take their place in the pews right next to the liars, gossips, materialists, and all the rest of us who entertain sin in our lives. ...The first lesson we learned is that to demonstrate Christ's love to the gay

> community you have to drop all pejorative, gay-bashing language from your vocabulary. The next thing we learned is to quit applying a double standard to new believers (p.22).

Moving Forward

Social research is showing that the churches which have been the most successful in creating any impact in the AIDS Crisis are those which have so adamantly embraced the "hate the sin but love the sinner" doctrine. According to Giles (1992), although many churches are reaching out it is happening "on a small scale" (p.46). He states,

> Many are heading in the right direction informally, in nonofficial ways, but they lack specific direction and example - sometimes from pastors, other times from denominational leaders higher up (p. 46).

Whatever the reason that churches have remained inactive (apathy, ignorance, fear, judgementalism) Giles contends the following

as ways in which the all churches can be prepared, reach out, and make an impact during the crisis:

- Establish guidelines and make preparations before the individual congregation is faced with a novel situation;
- Develop church wide policies which specifically address the issue;
- Remain supportive of AIDS education which not only presents factually correct information encourages abstinence and monogamy in their context.
- Don't keep the efforts of a congregation isolated within a congregation. Although the theological and doctrinal viewpoints may differ between congregations and other societal groups, focus the effort to "fight the disease, not the people with the disease."

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APPENDIX G

CULTURAL BOUNDARIES TO BE OVERCOME IN THE PLANNING OF EFFECTIVE HIV/AIDS EDUCATION

CULTURAL BOUNDARIES TO BE OVERCOME IN THE PLANNING OF EFFECTIVE HIV/AIDS EDUCATION

In an effort to reach out make a difference in the AIDS crisis, untold obstacles hinder the efforts of leaders and the effectiveness of leadership. One of the more difficult obstacles to bypass is the question of cultural boundaries which must be worked past, or at the very least considered, in the planning of HIV/AIDS education. This report is intended to present an overview of what various writers and researchers have stated in this area.

Culture Specific Programs

In the designing of realistic HIV/AIDS education programs, education and social science professionals must make their efforts sensitive to the needs of specific sub-groups in society. Croteau. et al. (1993) caution HIV/AIDS educators to be aware of "group specific misconceptions about HIV/AIDS that are barriers to effective

prevention and behavioral change" (p. 291). The work of these researchers shows that misinformation regarding the transmission of HIV is most prevalent among minority youth which essentially puts the minority youth at a greater risk of infection. The same researchers reported a random sample among African-Americans showing that 37 percent of college students and 17 percent of high school students actually believed that HIV was created in a laboratory as a means of eliminating the homosexual and black segments of society. Such ideas may seem ludicrous to the educated sector of society but are truly a deterrent to effective HIV/AIDS education.

Similar work was done by Magana and Carrier (1992). According to these researchers problems abound in attempting to implement HIV/AIDS education in the Mexican-American community because of an entirely different perception of homosexual and heterosexual roles. Their findings indicate that much, if not most, of the research data accumulated in the Anglo-American community is of little use in the Latin-American community.

Leap (1992) is a proponent of HIV/AIDS education programs which address the issues in the same jargon, vernacular, and/or nomenclature as the participants in the program regardless of how

crude, informal or the lack of standardization. It is a frequent situation that those teaching the program have a much higher level of formal education than those participating therefore presenting information at the appropriate level creates problems.

Overcoming Barriers

Kaemingk and Bootzin (1990) are among many researchers who insist that the attitude creating the most pronounced barrier to effective HIV/AIDS education is the perceived susceptibility of contracting the disease. In attempting to overcome the "self perceived risk", Bandura (1990) suggests that programs to generate self-directed change should contain four components:

(1) Information designed to increase awareness and knowledge of health risks;

(2) Development of social and self-regulatory skills needed to translate informed concerns into preventive action;

(3) Building self-efficacy through guided practice and corrective feedback;

(4) Enlisting social supports for desired personal changes (p.9).

Conclusion

Any effective HIV/AIDS education program will state an ultimate goal of saving lives. The effectiveness of any program will be greatly hindered if the objectives are not focused specifically on a target audience.

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APPENDIX H

SEPARATING THE FACTS FROM THE MYTHS IN THE AIDS CRISIS

SEPARATING THE FACTS FROM THE MYTHS IN THE AIDS CRISIS

Introduction

It is the purpose of any HIV/AIDS education program to prepare individuals to make informed decisions and choices and to know enough factually correct information so that they may ascertain what applies to them and what does not. The purpose of this report is to address some of the issues and most frequently asked questions concerning the transmission and prevention of HIV and AIDS.

What is HIV? What is AIDS?

HIV stands for the Human Immunodeficiency Virus which is known (according to some writers, believed) to cause AIDS. The acronym AIDS (Acquired Immune Deficiency Syndrome) was created in 1983 to officially name the syndrome for which so little was known.

At the time the syndrome was officially named, researchers had not actually isolated the virus which they only believed to be causing the symptomatic illnesses.

It is a common error among writers, speakers, or people a large that AIDS is referred to as a disease. AIDS is a syndrome which means a set of symptoms characterizing a condition. The media reports a certain number of "deaths from AIDS " when actually the people have not died of AIDS but from other conditions which have come about as the result of the syndrome.

What does HIV do?

When the virus enters the body it attacks the body's immune system making the person susceptible to diseases and other health conditions which would ordinarily pose no threat for a healthy person. The virus can live in the body of a person for as long as several years before the person will show any symptoms of having been infected. The virus eventually destroys the immune system to the point that even something as minor as a common cold can be devastating.

A person must be infected with the virus (known as being

HIV+), have a T-cell count under 200 and have one of several diseases before they are considered to have AIDS. Although there are many immunological disorders, a person who is not HIV+ cannot have AIDS.

How is the virus transmitted?

Epidemiologist have determined that the virus is spread through 4 specific bodily fluids:

(1) blood

(2) semen

(3) vaginal secretions

(4) breastmilk

The average HIV/AIDS education information does not point out that the bodily fluids which are known to transmit the virus are liquid tissues produced by the body which serve their purpose only when they are "alive". HIV is an extremely fragile virus and can survive only in a very limited environment. It cannot survive in bodily fluids which are waste (tears, sweat, urine, excrement). Waste matter cannot sustain the virus nor can the virus survive in air.

Transmission through saliva

The question of HIV transmission through saliva is discussed frequently. Epidemiologist are quite certain that saliva cannot sustain the virus. Saliva contains many enzymes which are designed to kill bacteria and viral matter and assist in chemically breaking down the food we eat.

There are reports which have stated that researchers have located the virus in the saliva of an infected person. An HIV/AIDS literate individual should recognize that while these scientists may have actually located the virus in saliva it would not have been a living virus because saliva is not a productive environment. A dead virus cannot hurt you.

Likewise, if the virus were actually discovered in urine or excrement it could not be alive. Urine is little more than the body's waste water mixed with salt and broken down dead proteins. Human urine cannot support the virus nor can human excrement.

Transmission through dental work

Kimberly Bergallis made national and international news when she publicly announced that she had contracted HIV through the work done by her dentist who was also an AIDS patient. The accusations, most of which were based on idea rather than clinical data, have completely revolutionized how dentists now practice.

An AIDS literate individual would know that although the virus is definitely transmitted through blood, any blood on a dental implement would be exposed to air which is not an appropriate environment for the virus. According to T. Seale (personal communication July 26, 1993) the virus can only survive about 4 seconds once it is exposed to air. It is very unlikely that a dental implement contaminated with infected blood could be put into another patient's mouth quickly enough to transmit the virus. It should be the responsibility of AIDS literate individuals to sort through the scientific data and not simply believe media hype.

Transmission through blood transfusions

In the early 1980's there was evidence but not totally conclusive evidence that the virus was present in blood. There are now pathological procedures for determining the presence of HIV in blood which are unmistakable and irrefutable. The difficulty is that it takes the human body several weeks beyond initial infection to develop a sufficient number of antibodies to show up in a lab test. (It has been generally reported that a period of 6 months should be allowed to assess if a person had developed antibodies to the virus. There are no documented Center for Disease Control (CDC)cases in which antibodies were not developed within 6 months after infection. More recent CDC reports indicate that pathological procedures are such that a 3 month period is accurate.) Those working in the blood industry have little way of knowing if a donor may have been infected a short time before donating blood.

Blood products which are processed and frozen pose no danger. If the virus were present it could not survive freezing temperatures.

The facts concerning transmission through blood are quite clear.

It is the responsibility of the informed adult to know the facts and if any risk is involved.

Transmission through pregnancy

The experience of this writer indicates a common misconception of the possibility of a baby being infected by a mother who is infected. It is absolutely possible for an HIV positive mother to infect her child in the womb but it does not happen every time an HIV positive woman gives birth.

Other myths about transmission

The possibility of HIV transmission through a mosquito bite is discussed frequently. There is absolutely no clinical evidence indicating such a possibility. In fact, the clinical evidence is quite conclusive that transmission through a mosquito bite is not possible.

Mosquitoes breed in wet areas. It is known by entomologists that the life span of a mosquito is only a few hours. During that short life span, the mosquito only bites once. In order for a mosquito bite to

transmit the virus it would have to bite twice - an infected person and a healthy person. Entomologists also know that the virus cannot survive inside the body of a mosquito. The mosquito is using what little blood they may have drawn from a human and therefore cannot sustain the virus.

There is also a question raised of the virus's ability to penetrate the latex gloves worn by medical professionals. Epidemiologist know the virus must survive inside the cells of the bodily fluid in which it is contained. While the virus itself may actually be small enough to pass through any pores in the latex, the virus itself will not likely survive if it did so. Common procedure is for practitioners to first wash their hands thoroughly, then put some type of talc on their hands to facilitate the putting on of latex gloves and to absorb perspiration. This would not be an environment in which the virus could survive.

A rip in the glove which would allow blood to pass through would possibly create a danger. This is the same danger posed by depending on condom use to prevent sexual transmission of the virus. Many reports state that condom use is only 80-90 percent effective. These figures are told to allow for the possibility that the condom may rip or be destroyed during sexual activity and not that the virus can

routinely pass through pores in the latex.

Why is there no cure at this time?

When the onset of AIDS came about in the early 1980's the medical community was absolutely unprepared for what would be medically and socially involved in battling this syndrome. Many of the early research efforts were not adequately funded or supported at the state and federal levels. Many of the discoveries that have been made have been accidental.

Epidemiologists and other AIDS researchers face challenges and difficulties not encountered in other areas of medicine. The AIDS virus is so fragile that researchers have a difficult time keeping laboratory specimens alive long enough to do any valid experimentation. Additionally, the virus mutates so quickly that by the time doctors have been able to isolate the exact virus in a persons body and develop any plan for treatment it has mutated to such a degree that any developed medications are not effective. At this time, the virus is still "smarter" than the medical community.

An HIV Literate Society

Separating the fact from the myth in the AIDS crisis must come about by having a society which is literate to the causes and preventions of HIV and AIDS. Although what is known is still inadequate to eradicate the syndrome, what is known is absolutely factually correct and is adequate to prevent further spread of the virus. It should be the responsibility of any adult to learn the facts, know the facts, and to make decisions accordingly.

APPENDIX I

WHY AIDS IS A TEENAGE PROBLEM

WHY AIDS IS A TEEN-AGE PROBLEM

Introduction

In the onset of the AIDS crisis researchers and educators attempt to target the segment of society which appears to be the most in need of HIV/AIDS education. Current research indicates that the segment of the total population through which HIV and AIDS is moving the most rampantly is heterosexual teenagers, particularly minority teens. This report is intended to provide an overview of how and why the teenage population is at a much higher risk of HIV than other segments of society and how and youth professionals should respond.

Teens at Risk

It is often stated in casual conversation that teenage pregnancy is on the rise, that teens are out of control, that teens are generally sexually promiscuous, etc. A report by Weiner (1986) reports that the

average person becomes sexually active at the age of 16. Likewise, Gibbs (1991) writes that by junior high school, 61 percent of the boys and 47 percent of the girls have engaged in full penetration sexual intercourse.

In light of this information, it is particularly alarming how uniformed teens and youth are in reference to the transmission of HIV. DuRant, Ashworth, Newman, and Gaillard (1991) published a study designed to measure what high schools students know about HIV and AIDS. Of the subjects studied, more than 50 percent were mistakenly informed that HIV can be transmitted through such means as mosquito bites, donating blood at a clinic, and using public toilets. The male subjects studied had less knowledge that the female subjects. The Hispanic subjects had less knowledge than non-Hispanics, and black subjects had less knowledge than white subjects. It was noted that the subjects with some formal HIV/AIDS training had more AIDS knowledge than those with no formal training.

In a related study, Gardner, Millstein, and Wilcox (1990) report that "the onset of sexual activity is earlier in males than females, earlier in black adolescents, and earliest in black males" (p. 261). Among persons ages 13-19 who have been infected with HIV the

female/male ratio is 3:1. It is clearly evident that effective HIV/AIDS education for teens is critical.

Factors Influencing Teen Behavior

Teens in the 1990's face stresses unlike what teens faced only a few years ago. Our nation's economy has made a comfortable family lifestyle virtually unaccessible to the average family. Violent crimes have filtered into even the respectable neighborhoods. More families than ever are torn by divorce and family breakup. The world of children is so uncertain that much of what has always been thought of as childhood is lost to the acquisition of survival skills.

According to Zeman (1990), teens today begin facing adult-like stress much too early. Family crisis, financial difficulties, and child-care situations cause teens to fill roles previously expected of adults. Similarly, Waldman and Springen (1992) indicate that 74 percent of high school juniors work after school jobs to help stabilize the family finances. This same report shows 84.5 percent of teens dating regularly. With their world so unstructured it is naive of child and youth professionals to assume teens will not seek refuge in

relationships.

What Makes a Difference?

There has been a considerable body of literature published concerning effective HIV education programs geared strictly to the teen population. Jemmott, et al. (1992) completed an HIV intervention project targeted at minority teens. The program consisted of a very intense five hour Saturday seminar with a three month follow up. The report showed positive results and continued HIV awareness.

Amer-Hirsch (1989) reports an HIV awareness program targeted to young girls in the New York area. The program provided hands-on experiences which allowed the girls to create awareness materials to be used at another time. The program also included opportunities for group counseling in which discussion ensued concerning personal fears about HIV, friends, and yourself. It is evident that the most effective programs are ones in which the participants are involved in some capacity other than that of passive listener.

Conclusion

Statistics clearly show the group within society which is experiencing the fastest transmission rate of HIV is teens. There is perhaps some argument as to rather or not the problem is a drug abuse or sexual problem. Regardless, the teen community needs to know the facts early enough that responsible, informed decisions are made.

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APPENDIX J

WHAT IS SAFE BEHAVIOR?

WHAT IS SAFE BEHAVIOR?

Introduction

In the midst of the terror created by the AIDS crisis, probably the most frequently asked question is "What can I do to keep myself safe"? There are facts published by numerous social, educational, and medical agencies specifically outlining what the medical community has established the public needs to know to prevent the transmission and spread of HIV. This report is intended to present an overview of the information needed to prevent or at least reduce the risk factors which are inherent by the presence of HIV.

Facts Applied to Practice

It is common knowledge that epidemiologist have determined and know the virus to be spread through 4 bodily fluids: blood, semen, vaginal secretions, and breastmilk. Likewise, it is common knowledge

that the virus is not spread through bodily waste such as tears, sweat, urine, excrement, or saliva. (Conservative writers are reluctant to state that saliva/kissing does not create a risk because if blood is present in the saliva, a risk may exist.) It is confirmed that the virus cannot survive airborne. Therefore, it is accurate to say that the only way to contract HIV is to have the virus enter your bloodstream directly.

Safe Behavior in Child Care

Frequently child and youth professionals are faced with emergency situations in which they must respond to a child who is ill, injured, or out of control. If placed in a situation where it is necessary to possibly be in contact with the bodily fluids of another person (even the bodily fluids which we know do not transmit HIV) it is critical to wear the latex gloves worn by medical professionals. The latex glove is referred to as the "barrier method" in that it creates a barrier between the caretaker and the possible infective agent.

Medical personnel are trained to first wash their hands thoroughly before putting on the gloves. Most of the latex gloves manufactured today have some type of talc inside to make it easier to

glove the hand. Following the treatment and the removal of the glove, the hands should again be washed thoroughly.

If gloves are not available and the situation is critical it is suggested that several layers of gauze, tissue, or fabric be placed between the hands of the caregiver and the injured while being very careful not to come into contact with blood. The hands should be washed as frequently as possible with hot soapy water if possible.

Safe Sexual Behaviors

Many social science, educational, and medical authorities are extremely vague when it is necessary to discuss safe sexual behaviors, possibly because of the social discomfort caused by the sensitivity of the topic. It is commonly known that the virus is only transmitted through specific bodily fluids therefore we can logically deduce that simply avoiding intimate contact with those fluids essentially eliminates the risk of infection.

Many agencies which provide HIV and AIDS counseling suggest some guidelines and/or boundaries in ones sexual practices to avoid the risk of infection:

(1) Avoid contact with the sexual bodily fluids which are known to transmit HIV. The use of a latex condom during any penetrative sexual activity is strongly encouraged. The use of a dental dam (or even commercial plastic wrap) during vaginal oral sex is strongly encouraged. The use of latex gloves during any type of manual penetrative sexual activity is strongly encouraged.

(2) Limit the sexual partners. The more times a gamble is taken, the greater the chances for misfortune.

(3) Use common logic to make your sexual activities first emotionally fulfilling, then physically fulfilling.

Remaining Safe

The most critical weapon in the war on AIDS is common logic. The medical community has clearly established what the public needs to know about AIDS in order to avoid tragedy. It is the responsibility of the HIV literate adult to use the information to its fullest applicability.

APPENDIX K

DOES EDUCATION HELP IN MODIFYING RISKY BEHAVIOR?

DOES EDUCATION HELP IN MODIFYING RISKY BEHAVIORS?

Introduction

When the issue of HIV education is presented several questions must be asked including the cost, feasibility, and probable effectiveness of the effort. While any education program which saves even one life is money and effort well spent, practical implications must question the cost and effort in relation to the outcome. This report is intended to overview some programs which HIV educators have used and their effectiveness.

Programs That Have Worked

There has been a great body of literature published concerning various HIV education projects which were targeted to various groups falling somewhere between a high risk category and a category of no

risk. In addressing what many perceive as the groups at highest risk, Tudiver (1992) completed a study involving 612 gay and bisexual men. After establishing norms and validating the pre- and post-surveys, the men were divided into two groups. One had a very intense educational session lasting several hours while the others were presented the same information in shorter sessions which would happen over several weeks. When the study was complete, both sets of subjects showed significant gains in their levels of AIDS knowledge and in the attitudes toward safer behaviors.

Research indicates that the most effective programs are those which are targeted to specific at-risk groups. When a community in New Haven, Connecticut was experiencing a disproportionately high incidence of HIV in females (presumably as a result of drug abuse), Kurth & Champoux (1990) completed a community based AIDS outreach program in which their preliminary efforts showed a statistically significant need for serious HIV/AIDS education and intervention programs. The remainder of the project was to have been a combination of group meetings, printed materials, and some involvement through local churches.

Carter & Jalloh (1990) presented an HIV education program to

migrants. The program components consisted of meetings at the local migrant center, church/community seminars, health advisory training, neighborhood clinics which serve as resource points, and technical consultation which include interpretation services for those migrants who do not speak English.

Amer-Hirsch (1989) reported an HIV/AIDS awareness program targeted to young girls in the New York area. This program provided sessions which not only presented factual data but allowed the participants to be more involved than at the level of passive listening by having them prepare posters, worksheets, etc. which would be used in subsequent meetings. When the project was evaluated according to plan there was a 96 percent increase in the HIV/AIDS knowledge of the participants.

Education That Works

The HIV literate adult should recognize that certain components inherently lend themselves to an increased effectiveness in HIV/AIDS education programs. House & Walker (1993) report that HIV education programs which are planned according to the "bottom up" style of

management rather than the "top down" style of management are more conducive to effective results because of the level of participant involvement. Croteau, et al. (1993) believe that HIV/AIDS education programs which include such components as educating the group leaders first, theater presentations, and rap music contests produce better results than simple "lecture" type programs. These researchers also report a tremendous result from a week-end retreat format where the leaders model appropriate behavior. It is essentially their position that involvement by the participants rather than passive listening produces better results.

Does Education Make a Difference?

When the question is asked, "Does education make a difference?", the answer must be yes. The real question to be addressed is how to design the program to meet the specific needs of the specific at risk group.

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APPENDIX L

WHAT TEACHERS NEED TO KNOW TO MAKE A DIFFERENCE

WHAT TEACHERS NEED TO KNOW TO MAKE A DIFFERENCE

Introduction

The roles and responsibilities of child and youth professionals in the AIDS crisis are undefined, or at best, unclear. Federal, state and local mandates dictate what child and youth professionals can and cannot say or do in the scope of effective HIV/AIDS education. This report is intended to present some general guidelines as to what teachers need to know to be prepared to make a difference.

Know State and Local Policy

The rules and policies concerning HIV/AIDS education in the schools as well as policies and procedures for dealing with those affected by the syndrome differ in each individual work setting. It should be the responsibility of the individual professional to seek out

resources and be well informed as to the accepted policy and procedure in the work setting. While opinions and ideas vary widely as to how liberal HIV/AIDS education practices should be, it is far better to err on the side of caution than to counsel a child in a manner not allowed for in local policy.

Know the Facts

In order for teachers and other child and youth professionals to truly make a difference in the AIDS crisis, they must first know the facts and the truth about the syndrome, how it is and is not transmitted, the illnesses caused by the syndrome, and how to avoid possible infection. The facts concerning HIV transmission are quite clear. Again, the informed child and youth professional should make available public resources so that they can make informed choices in dealing with issues involving children and youth.

Remain Informed

As in any area of research, new information is constantly

acquired. The informed child and youth professional should be attentive and alert to new information which may prove to be of value in addressing the AIDS crisis in relation to children and youth. While the facts which are now clearly established will not likely change, information concerning the use of those facts will be generated which may or may not prove useful to the child and youth professional. The effective child and youth professional will be informed enough to know which information is relevant and/or valid and which is not.

Common Logic

It has been clearly established that a great amount of misinformation exists in the general public, even among the very educated. An individual does not need an extensive background In chemistry or biology to recognize that much of what is told/repeated/talked about concerning HIV and AIDS cannot possibly be true. The informed child and youth professional will use common logic in interpreting the media reports concerning AIDS. Informed professionals will recognize that numbers alone mean very little if not placed n perspective. Likewise, numbers mean very little in relation to

a persons likelihood of becoming infected if the person is taking the precautions which the medical community knows are effective.

Making a Difference

Knowing the facts, the rules concerning local policy, and being generally informed can have as far reaching effects in the AIDS crisis as any extravagantly designed program of HIV/AIDS education. Informed teachers and other child and youth professionals will be prepared to make a difference.

APPENDIX M

CONTINUING EDUCATION RESOURCES

RESOURCES FOR CONTINUING HIV/AIDS EDUCATION

AIDS Information Hotlines

National AIDS Hotline	1-800-342-AIDS
Spanish AIDS Hotline	1-800-344-7432
Hearing Impaired AIDS Hotline	1-800-243-7889
National AIDS Information Clearinghouse	1-800-458-5231
Project INFORM (AIDS Experimental Drug Info.)	1-800-822-7422
American Foundation for AIDS Research (AmFAR)	1-212-719-0033
National AIDS Network	1-202-293-2437
Pediatric and Pregnancy AIDS Hotline	1-212-227-8922
National Sexually Transmitted Disease Hotline	1-800-227-8922

Public Health Services AIDS Hotline	1-800-342-AIDS (English)
	1-800-342-SIDA (Spanish)
	1-800-AIDS-TTY (Hearing Impaired)

AIDS Related Serials of Interest to Child and Youth Professionals

AIDS Education and Prevention

Subscriptions, Guilford Publications

72 Spring Street

New York, NY 10012

AIDS Information Source Book

Onyx Press

2214 North Central at Encanto

Phoenix, AZ 85004

AIDS Education

National Professional Resources

P. O. Box 1479

Port Chester, NY 10573

Suggested Readings on HIV/AIDS for

Child and Youth Professionals

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APPENDIX N

LETTER OF REQUEST

LOUISIANA STATE UNIVERSITY MEDICAL SCHOOL

SCHOOL OF
MEDICINE IN NEW ORLEANS
Louisiana State University
Medical Center
1542 Tulane Avenue
New Orleans, LA 70112-2822
Telephone: (504) 568-6221
FAX: (504) 568-7532

Department of Pediatrics

February 1, 1994

Mr. Norman Dale Norris
1735 Milan Street
New Orleans, LA 70115

Dear Mr. Norris,

I understand from Mr. Seale that you are near completion of a doctoral level project on HIV/AIDS education for child and youth professionals.

I would appreciate having a copy of the project when it is completed and approved by your university.

Sincerely,

Gary Q. Peck, M.D.
Associate Professor
Ambulatory Pediatrics
568-7530